Underhill Optometry

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Last Name: _____ Given Name: _____ Preferred Name: _____

Address: _____

City: _____ Postal Code: _____ Preferred telephone #: _____

Date of Birth: _____ Alternate telephone #: _____

OHIP #: _____ Email: _____

What is your reason for today's visit? _____

Date of last eye exam: _____ Optometrist's Name: _____

Date of last medical: _____ Doctor's Name: _____

Do you wear glasses? Yes ☐ No ☐

Do you wear contact lenses? Yes ☐ No ☐ If yes, what brand/type of lens? _____

If no, are you interested in contact lenses? Yes ☐ No ☐

Have you had any eye surgery? If yes, what kind? _____

Are you interested in Laser Eye Surgery? Yes ☐ No ☐

What is your occupation? _____ How much screen time do you have each day? _____

Do you see double? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

Do you, or any of your blood relatives, have (or have had) any of the following?

Glaucoma	Yes	No	Macular Degeneration	Yes	No
Cataract	Yes	No	Strabismus/Lazy Eye	Yes	No
Retinal Detachment	Yes	No	Blindness	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No
Thyroid Disease	Yes	No	Arthritis	Yes	No
Asthma	Yes	No	Sleep Apnea	Yes	No

Other: _____

Are you currently taking any medications? If so, please list _____

_____

Do you have any sensitivity or allergies to any medications or substances? _____

How did you hear about our office? _____